BILLING GUIDELINES

All claims must be submitted on:

- Health Insurance Claim Form-CMS 1500; or
- UB 04 from hospitals.

Each invoice should:

- Cover no more than one month of services for all clients served by the Provider;
- List each client's Department Client Number (DCN);
- Indicate the date service was provided; and
- Indicate the procedure code and number of units for the service provided.

DETERMINING BILLING UNITS

- Use the attendance record for the client for the date of service;
- Add the number of units that most closely approximates the time the client received the service; and
- Multiply the Reimbursement Rate for the service received by the number of units the client received on that date. (Contact time).

When the time of service exceeds a unit time, the Provider is entitled to bill for the next unit up to the total number of units approved.

- **Example 1:** The client attended the scheduled service the entire week, however, missed one entire afternoon for a medical appointment. The client was prior approved for five (5) full days. The billable number of units is: Five (5) full days. Since there are two different codes for full and half days, even though the participant did not attend for a full day, a half-day unit has not been approved, and will be rejected.

- **Example 2 (1/4 hour unit):** The client attended the scheduled service for 50 minutes. The client was prior approved for four (4) units. The billable number of units is four (4) units, since the client attended for a portion of the fourth unit of the approved time.

SUBMITTING THE INVOICE

One copy of the invoice form should be submitted to:
Missouri Department of Health and Senior Services
Special Health Care Needs
Adult Head Injury Program
P.O. Box 570
Jefferson City, MO 65102-0570

All billings for approved services provided to approved clients must be submitted to the Department no later than sixty (60) days following the date services are provided or no later than sixty (60) days following receipt of payment determination by a third party payer. At the close of a state fiscal year, Providers may be notified by Special Health Care Needs (SHCN) to submit claims at an earlier date to ensure timely payment.

SHCN will not provide co-payment for services covered under any other program (MO HealthNet, Medicare, or private insurance).

When clients are covered by third-party payers that also cover the billed service, approval can be considered for payment only if a written denial has been submitted with each request for approval of services (Prior Authorization Form).

The Provider should allow 45 days for claims processing.

Invoices will be reimbursed at established rates outlined in the Provider Manual and as prior authorized. When the claim has been processed, a voucher will be sent at the time of payment to the address listed during Provider enrollment.

If a claim is rejected for any reason, an explanation will be printed on the voucher. Typical reasons for rejection may include:

- Service not prior authorized; and
- Claim not filed within 60-day timeline.

CREDIT INVOICES

Credit invoices will be processed in the following circumstances:

- Duplicate payments;
- Insurance payments;
- MO HealthNet payments;
- Payments made in error; and
- Over payments.

The credit will be reflected on the next payment and voucher processed to the Provider. Refunds should not be sent unless requested from the Department of Health and Senior Services (DHSS).

CORRESPONDENCE

Any correspondence or payment sent by the DHSS will be sent to the address shown on the Provider Participation Agreement. It is the responsibility of the Provider to notify SHCN if the contact person or address change.

MONITORING

Providers must maintain accurate client invoice files. DHSS has the authority to review client records and Provider billings. Program Staff will monitor all providers periodically.

APPEALS

To appeal a claims decision, the Provider must submit the following information in writing within 30 days of issuance of DHSS voucher:

- Copy of original invoice listing client's name, DCN, date of service;
- Brief written statement indicating reason for appealing the DHSS claims decision; and
- Any supporting documents required.

After review by DHSS, a response will be sent to the Provider within 30 days.